



THE INTERSECTION OF TRAUMA AND SUBSTANCE USE DISORDERS

9th Annual Prescription Drug Use Symposium

Maria P. Hanzlik, PsyD, HSPP

Clinical Psychologist

Indiana Psychological Association President-Elect

Contact Information

Maria Papachrysanthou Hanzlik, PsyD, HSPP

dr.mariaphanzlik@gmail.com

Integrated Psychological Center of Indiana

50 E. 91st Street, Suite 316

Indianapolis, Indiana 46240

317-550-3221

drmariahanzlik.com

Agenda

- Definition/Prevalence of Trauma
- Comorbidity of SUD and Trauma
- Evidence-Based Treatment
 - *Seeking Safety*

TRAUMA

What Is Trauma?
Prevalence of Trauma

Single-Incident (“Type I”) vs. Complex Trauma (“Type II”)

■ Type I/Single Incident

- An “out of the blue”/unexpected event
 - *Traumatic accident*
 - *Natural disaster*
 - *Single episode of abuse or assault*
 - *Witnessing violence*
- More consistent with DSM criteria

■ Type II/Complex/Repetitive Trauma/Complex PTSD

- Ongoing, severe abuse.
- Perpetrated by someone known by or related to the victim/survivor.
- Betrayal of trust in primary relationships
 - *Domestic violence*
 - *Community violence*
 - *War*
 - *Genocide*
- Associated with a higher risk of PTSD (p. 15)
- When it occurs during critical developmental periods, TII trauma can compromise psychobiological and socioemotional development (development of the self)

DSM-5 Criteria for Posttraumatic Stress Disorder (PTSD)

- A. *Exposure to actual or threatened death, serious injury, or sexual violence (1+):*
 - 1.) *Directly experiencing the traumatic event(s).*
 - 2.) *Witnessing, in person, the event(s) as it occurred to others.*
 - 3.) *Learning that the t. event(s) occurred to a close family member/friend.*
Actual/threatened death: event(s) must have been violent/accidental.
 - 4.) *Experiencing repeated or extreme exposure to aversive details of the traumatic event(s)—first responders collecting human remains, police officers repeatedly exposed to details of child abuse.*

DSM-5 Criteria for Posttraumatic Stress Disorder (PTSD)

■ B. Presence of 1+ intrusion symptoms:

- 1.) Recurrent, involuntary, and intrusive distressing memories of the trauma. (Children > age 6, repetitive play...)
- 2.) Recurrent distressing dreams of the event in which the content and/or affect of the dream are related to the traumatic event.
- 3.) Dissociative reactions (e.g. flashbacks) in which the individual feels or acts as if the traumatic event (s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings).
- 4.) Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
- 5.) Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event.

DSM-5 Criteria for Posttraumatic Stress Disorder (PTSD)

- *C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by (1+):*
 - *1.) Avoidance of or efforts to avoid distressing memories, thoughts or feelings about or closely associated with the traumatic event(s).*
 - *2.) Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).*

DSM-5 Criteria for Posttraumatic Stress Disorder (PTSD)

- *D. Negative alterations in cognition and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by (2+):*
 - *1.) Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).*
 - *2.) Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g. “I am bad,” “No one can be trusted,” et al.)*
 - *3.) Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame self or others.*
 - *4.) Persistent negative emotional state (fear, horror, anger, guilt, shame).*
 - *5.) Markedly diminished interest or participation in significant activities.*
 - *6.) Feelings of detachment or estrangement from others.*
 - *7.) Persistent inability to experience positive emotions (e.g. happiness, satisfaction, or loving feelings).*

DSM-5 Criteria for Posttraumatic Stress Disorder (PTSD)

■ *Specifiers:*

- *With dissociative symptoms:*
 - *Depersonalization: Persistent or recurrent experience of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g. feeling as though one were in a dream; a sense of unreality of self, body, or time moving slowly).*
 - *Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g. the world experienced as unreal, dreamlike, distant, distorted).*
- *With Delayed Onset (full diagnostic criteria not met until at least 6 months after, even if some symptoms are met).*

Prevalence of Abuse: Children (ACE Study)

Psychological Abuse: 11.1% (*Did a parent or other adult in the household . . .*)

- *Often or very often swear at, insult, or put you down?: 10.0%*
- *Often or very often act in a way that made you afraid that you would be physically hurt?: 4/8%*

Physical Abuse: 10.8%

- *Often or very often push, grab, shove, or slap you? 4.9%*
- *Often or very often hit you so hard that you had marks or were injured?: 9.6%*

Sexual Abuse: 22.0%

- *Touch or fondle you in a sexual way? 19.3%*
- *Have you touch their body in a sexual way? 8.7%*
- *Attempt oral, anal, or vaginal intercourse with you? 8.9%*
- *Actually have oral, anal, or vaginal intercourse with you? 6.9%*

Prevalence of Abuse: Children (ACE Study)

Witness Violence Against Mother: 12.5% *Was your mother (or stepmother)*

- Sometimes, often, or very often pushed, grabbed, slapped, or had something thrown at her? **11.9%**
- Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? **6.3%**
- Ever repeatedly hit over at least a few minutes? **6.6%**
- Ever threatened with, or hurt by, a knife or gun? **3.0%**

Household Members as Substance Abusers: 25.6%

- *Often or very often push, grab, shove, or slap you?* **4.9%**
- *Often or very often hit you so hard that you had marks or were injured?:* **9.6%**

Prevalence of Abuse: Children (ACE Study)

Household Members with Mental Illness: 18.8%

- Was a household member depressed or mentally ill? 17.5
- Did a household member attempt suicide? 4.0

Criminal Behavior in Household:

- Did a household member go to prison? 3.4%

Any Category Reported: 52.1%

Prevalence of Abuse: Children (ACE Study)

- Individuals with 4+ categories of childhood exposure had **4- to 12-fold increase** in health risks for:
 - *Alcoholism*
 - *Drug Abuse*
 - *Depression*
 - *Suicide Attempt*
- **2- to 4-fold increase** in health risks for:
 - *Smoking*
 - *Poor self-rated health*
 - *>/=50 sexual intercourse partners*
 - *Sexually transmitted disease/infection*

ACEs & Substance Use Disorders (SUDs)

- **Prescription drug use.** For every additional ACE score, the rate of number of prescription drugs used increased by 62%, according to a [2017 study of adverse childhood experiences and adolescent prescription drug use.](#)

ACEs & Substance Use Disorders (SUDs)

Health Problem	# Categories	Sample Size (N)	Prevalence %
Considers self an alcoholic	0	3,841	2.9
	1	1,993	5.7
	2	1,042	10.3
	3	586	11.3
	4+	540	16.1

ACEs & Substance Use Disorders (SUDs)

Health Problem	# Categories	Sample Size (N)	Prevalence %
Ever used illicit drugs	0	3,856	6.4
	1	1,998	11.4
	2	1,045	19.2
	3	589	21.5
	4+	541	28.4

ACEs & Substance Use Disorders (SUDs)

Health Problem	# Categories	Sample Size (N)	Prevalence %
Ever injected drugs	0	3,855	0.3
	1	1,996	0.5
	2	1,044	1.4
	3	587	2.3
	4+	540	3.4



Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan



ACE PYRAMID

Secondary/Tertiary Prevention of Effects of ACEs

- Secondary: Intervening when the events occur
 - *Recognition that ACEs have occurred (assessment)*
 - *Behavioral intervention to reduce the emotional impact of the experiences*
- Tertiary Prevention: Intervening with adults who have experienced ACEs
 - *Physicians to screen adults for exposure to violence when entering the health system (rare).*
 - *Research shows patients would welcome questions about ACEs as important to routine medical care.*

Prevalence & Nature of Trauma and Substance Use Disorders

- At least **50%** of individuals with substance use issues will also experience PTSD symptoms at some point in their lives (Killeen, Back & Brady, 2011; Souza & Spates, 2008).
- Individuals with substance use issues as well as PTSD having difficulty coping with stress and have poorer life outcomes than those with either disorder alone (Najavits & Johnson, 2014)

Prevalence & Nature of Trauma and Substance Use Disorders

- PTSD and SUDs are common (12-34%, 30-59% for women)
- Abstinence from substances does not resolve PTSD; symptoms can often worsen.
- Individuals with PTSD often use prescription medications to cope with overwhelming emotional pain of trauma.
- Individuals with PTSD and SUDs are more vulnerable to experiencing additional traumas than those with SUDs alone.

SEEKING SAFETY

An Evidence-Based Treatment Strategy



Seeking Safety: An Effective Treatment for Co-Morbid Trauma and SUDs

- Study 1: Asian Pacific AIDS Intervention Team's Project Heal"
 - *Ethnic minority transfemale population*
 - *12 weeks of Seeking Safety*
 - *Tested at Intake, Discharge, 6-month follow-up*
 - *Results:*
 - Reduction in substance abuse, anxiety and depression, PTSD symptoms
 - Increase in employment, personal rating of overall health, increase in social support

Seeking Safety: An Effective Treatment for Co-Morbid Trauma and SUDs

- A 2005 study on men with PTSD & SUD (Najavits, Schmitz, Gotthardt, & Weiss, 2005).
 - *30 sessions over 5 months*
 - High levels of treatment satisfaction
 - Reduced trauma symptoms
 - Reduction in drug use

Seeking Safety: Treatment

- A psychotherapy manualized treatment for both PTSD and substance use.
- Can be conducted as group or individual therapy.
 - *50- or 90-minute individual or group sessions*
 - *Closed or open groups*
 - *1 or 2 group leaders*
- Consists of 25 topics that is broken up into cognitive, behavioral, and interpersonal areas.
- Assists with stabilizing individuals who require “first-stage treatment” for trauma and substance use.
- Participants do not have to meet full criteria for PTSD and SUDs to benefit.
- Topics can be introduced in any order.

Seeking Safety: Treatment

- Introduction to Treatment/Case Management
- Safety (Safe Coping Skills)
- PTSD: Taking Back Your Power
- Detaching from Emotional Pain (Grounding)
- When Substances Control You
- Asking for Help
- Taking Good Care of Yourself
- Compassion
- Red & Green Flags
- Honesty
- Recovery Thinking
- Integrating the Split Self
- Commitment
- Creating Meaning
- Community Resources
- Setting Boundaries in Relationships
- Discovery
- Getting Others to Support Your Recovery
- Coping with Triggers
- Respecting Your Time
- Healthy Relationships
- Self-Nurturing
- Healing from Anger
- The Life Choices Game (Review)
- Termination

Seeking Safety: Treatment Differences

- Cognitive-Behavioral Therapy (CBT): Manuals for PTSD and for SUD exist, but not for the combination.
- Dialectical Behavior Therapy (DBT): A longer, more intensive treatment (group and individual). Different skills taught. Does not specifically address PTSD.
- Exposure Therapy for PTSD: Exposes individual to trauma memories and triggers. Briefer (9-12 sessions). Does not address SUDs, case management, in-depth work on coping skills.
- Motivational Interviewing: Treatment for SUDs that focuses on “rolling with resistance,” “expressing empathy,” and “avoiding argumentation”. Does not rehearse coping skills, address dual diagnosis or PTSD.
- 12-Step Programs: Focus on substance use alone, not PTSD (many of them). Advocate abstinence model. Not designed to be led by clinicians. No explicit rehearsal of coping skills. Compatible as an adjunct with SS.

QUESTIONS/REFLECTIONS



Finding Providers

- Indianapsychology.org: Find a Psychologist
- Psychology Today

References

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

Felitti, V. J., Anda, R., Nordenberg, D., Williamson, D.F., Spitz, A. M., Edwards, V., Koss, M. P., Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventative Medicine*, 14 (4).

Feuerberg, T. (2018). Outcomes of ethnic minority transfemale participants in a longitudinal co-occurring PTSD and substance abuse program. *Dissertation Abstracts International Section A: Humanities and Social Sciences*, 79(8-A(E)).

Najavits, L. M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. The Guilford Press: New York.

SAMHSA (2018). SAMHSA.GOV.